# *in* INNOVATIONS COOPERATION

## A GUIDEBOOK ON BILATERAL AGREEMENTS TO ADDRESS HEALTH WORKER MIGRATION

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# ACKNOWLEDGEMENTS

The Health Worker Migration Initiative (HWMI) is a partnership between the World Health Organization, the Global Health Workforce Alliance, and Realizing Rights/Global Health & Development at The Aspen Institute. HWMI aims to develop and promote innovative policy solutions to address the growing global problem of inequitable healthcare access due to the migration of health workers. HWMI was formally launched May 15, 2007 in Geneva during the World Health Assembly.

The Health Worker Migration Global Policy Advisory Council is chaired by the Honorable Mary Robinson and Dr. Francis Omaswa, and is composed of high level policymakers from both source and destination countries, as well as leading health, labor, and migration experts. Realizing Rights and its legacy program, Global Health & Development, serve as the secretariat for the Council.

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# FOREWARD

We are experiencing a global health workforce shortage of stunning proportions: 4.5 million health workers are needed globally, with a full one million needed in sub-Saharan Africa alone. Demographic changes and medical advances have led to an increased pull from developed countries for health workers from all over the world, a phenomenon that is projected to last for decades to come.

Health worker migration provides a dramatic amplification of what has been going on for years with no apparent solution: “brain drain,” the loss of many developing countries’ best and brightest to wealthier nations, leaving these nations ill equipped to build viable health care systems in the face of massive out-migration. Clearly, this is but one more example of profound disparities in global health. Yet, in the midst of this crisis, there is promise, and rays of hope.

Some nations, recognizing the consequences of their reliance on health workers from poorer countries, have asked how they can engage more ethically with countries from whom they are receiving health workers and who are hard-hit by out-migration. For example, Norway recognized its need for close to 40,000 additional health workers over the next decade and its reliance on migrating health workers from poorer nations, notably Poland and other countries of Eastern Europe, and formed a cabinet-level multi-sectoral policy group. This body aims to develop a more ethical and sustainable health workforce policy to bring coherence and new vision to their domestic health workforce and international development assistance policies. The European region as a whole has developed a Green Paper on the European Workforce for Health (2008) that includes commitments to put in place a set of principles regarding recruitment of health workers from developing countries.

A few pioneering countries that receive foreign-trained health workers have established bilateral agreements with their primary source countries to guide recruitment, exchange, and development assistance between them. The UK-South Africa Memorandum of Understanding, complimented by simultaneous internal UK policy to increase domestic production of health

care workers, was among the first. These emerging policy innovations point the way forward to a new, more cooperative and collaborative approach to ethically and efficiently manage the demand for health care workers globally. As a weak health system anywhere is a weak health system everywhere, it is in the best interest of all to search for methods to address the global imbalance of health care workers. We hope this report, *Innovations in Cooperations: A Guidebook on Bilateral Agreements to Address Health Worker Migration*, will provide ideas and guidance for policymakers to explore new ways to cooperate with partner countries around the critical issue of health worker migration.

**Margaret E. Clark**

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*"Globalization envisages a worldwide community without borders for money or for products…yet in the next several decades the combination of migratory pressures, generated by uneven demographic growth and unevenly distributed global poverty, and the social consequences of the uneven aging of national populations may very well transform the political face of the earth.*

*...In the final analysis, a globalization that indifferently favors the rich and copes with the human misery of migration in a manner that benefits the already privileged will be a globalization that justifies its critics, mobilizes its enemies, and further divides the world. Only a world that is both increasingly imbued with a shared social conscience and more open to the movement—even if regulated—of not just goods and funds, but people as well, will fulfill the positive potential of globalization."*

— Zbigniew Brzezinski, The Choice: Global Domination or Global Leadership, 2004

*The flood of illegal unskilled migrants into rich countries and the "brain drain" of skilled citizens from the poorest countries are two of the most critical current issues in international migration today.*

*These problems, as well as issues such as international trafficking in women and children, have highlighted a gaping hole in the international institutional architecture. We have only a fragmented set of institutions to deal with flows of humanity. The International Labour Organisation looks after workers rights. The United High Commissioner for Refugees deals with forced migrants. The World Trade Organisation, under its services agreement, manages the temporary access of professional and semi-professional workers – from builders to doctors – to other countries. The International Organization of Migration is a cross between a consulting body and an altruistic group. Besides its status is not defined by a treaty. Indeed, we do not have a treaty-defined "World Migration Organisation" (WMO) that could oversee the whole phenomenon, according to internationally agreed objectives and procedures.*

- Jagdish Bhagwati, Financial Times, October 24, 2003

*"The objective of the World Health Organization (hereafter called the Organization) shall be the attainment by all peoples of the highest possible level of health."*

- Article 1, WHO Constitution

*"Sharing in the vision of a world abundant in opportunities to work and train abroad, rich in the e xchange of ideas and expertise in the pursuit to further global health, and where every country also has a safe minimum number of trained health workers."*

-Health Worker Migration Initiative, Global Policy Advisory Council Recommendations Report: Recommendations on WHO's Draft Code of Practice on the International Recruitment of Health Personnel, 2008.

# 1 EXECUTIVE SUMMARY

There is limited international structure to manage the ever important phenomenon of human migration and its associated challenges. This is particularly true with respect to the international migration of health workers, where bilateral agreements between sending and receiving nations have been repeatedly and urgently called for in the context of a global health workforce crisis. There remains, however, significant lack of clarity on the precise role, form, and content bilateral agreement should take to serve a health-related purpose. The authors through this Guidebook, including presentation of two model bilateral agreements, aim to provide some initial but concrete guidance to further international cooperation around the critical and highly sensitive area of health worker migration.

There is clear evidence that the international migration of health workers is increasing and that the movement is, for the most part, not bi-directional, particularly for the low-income sub-Saharan African and Caribbean nations who are among the most affected. Encouragingly, the last decade has witnessed the emergence of an international structure, albeit largely voluntary, attempting to manage health worker migration flows in a manner that ensures mutual benefits for source nations, destination nations, and migrant health workers themselves. Central to this structure, including within the recently developed draft WHO Code of Practice on the International Recruitment of Health Workers, is a call for bilateral agreements to serve as a health solution to the challenges associated with the international migration of health personnel.

There remains, however, significant lack of clarity on the precise role, form, and content of bilateral agreements to serve a health-related purpose. This lack of clarity poses a particular challenge for developing countries, which have the most at stake. The authors of this report, with particular focus on serving the needs of particularly affected developing countries, hope to provide some initial but concrete guidance on the development of bilateral agreements as necessary to further international cooperation to mitigate the negative effects associated with health worker migration.

The Guidebook provides an introduction to bilateral agreements, their legal status, and points to the heterogeneity and challenges present in relation to bilateral agreements serving as a solution to the issue of health worker migration. Challenges include the differing approaches to bilateral agreements necessary in relation to differing forms of national immigration policy and the failure in the past of bilateral agreements to fully engage with the concept of migration and development. There have been recent innovations in developing comprehensive bilateral migration agreement that seek to simultaneously facilitate the movement of health workers and respond to challenges associated with such migration. Recent procedural innovations

in other sectors, including importantly in climate change cooperation, also provide an approach to bilateral agreements aiming to further cooperation between nations on complex and sensitive issues.

The Guidebook presents two bilateral agreement prototypes. They are relevant both to countries who recruit and facilitate admission through bilateral agreements and to countries who instead rely on 'quality-selective', 'non-discriminatory' immigration, as well as decentralized recruitment, policies. **Model Bilateral Agreement I** presents a comprehensive approach to managing health worker migration flows. It been developed through collection and analyses of a significant variety of existing instruments (available through Annex A). The model is useful both as a reflection of existing practice and also as a means to implement the recommendations presented in the draft WHO Code of Practice on the International Recruitment of Health Personnel. **Model Bilateral Agreement II** presents an innovative process of dialogue and cooperation for countries as yet unable to agree upon the precise measures to address the negative effects of health worker migration.

Just as important as what this guidebook presents is what it does not. The report provides guidance on the formulation of bilateral agreements, with particular emphasis on text. The guidebook is not an analysis of the operation in practice of collected bilateral agreements, where little documentation or rigorous evaluation exists. Much work needs to be done here, as pointed to in the report, particularly around the operation of bilateral implementation and coordination-related bodies.

The Guidebook additionally raises the open questions of whether liberalization of trade in services and the associated mutual recognition agreements can serve to address the challenges associated with health worker migration or are in conflict with efforts to do so. The report concludes by calling for greater efforts to increase transparency in making the texts of bilateral agreements available so that the international community can continue to learn from existing practice and to encourage accountability to what is agreed within them.

# 2 INTRODUCTION

## INTERNATIONAL MIGRATION OF HEALTH WORKERS

Health workers reside at the core of an accessible, equitable, and responsive health system and are essential to progress towards the health-related Millennium Development Goals.[1] An adequate health workforce is similarly central to progressively realizing the human right to health in both developed and developing countries.[2]

The world, however, is currently in the midst of a global health workforce crisis, with an additional four and a half million health workers urgently required.[3] Sub-Saharan Africa, as a particularly stark example, carries twenty-four percent of the global burden of disease but has just three percent of the world's health workforce and requires more than a million additional health workers to meet the basic health needs of its population.[4] Indeed, of the fifty-seven countries identified by the World Health Organization as facing critical health workforce shortages, thirty-six are in sub-Saharan Africa.

Coupled with the existing global shortage and inequitable distribution of health workers is the ever-growing global demand for health workers. This is driven in large part by aging populations in North America and Europe, the shifting global burden of disease, changing methods in global health care delivery, as well as by the emerging hubs of health care delivery found in the Gulf States and in South-East Asia. The growing demand for health workers in middle- and high-income countries is increasingly being met through reliance on foreign health workers, often from low-income nations. The OECD, through its 2007 report, determined that 18% of doctors and 11% of nurses working in OECD nations were foreign born and that the international migration of health workers to OECD nations was increasing.[5]

While India and the Philippines are the largest suppliers of health workers in terms of sheer numbers of doctors and nurses, respectively, African and Caribbean countries are disproportionately affected by the emigration of their health workers to OECD countries. For example, over 50% of the physicians from Angola, Antigua and Barbuda, Grenada, Guyana, Haiti, Liberia, Mozambique, Saint Vincent and the Grenadines, Sierra Leone, Tanzania, and Trinidad and Tobago, practice as expatriates in OECD countries.[6] Ghana, one of the three largest African suppliers of health workers, has 30% of its potential physician workforce serving the needs of the U.S. population.[7]

The unmanaged migration of health workers from the South to the North has been identified by many as producing a development gain for nations already resource-rich and a development loss for the countries and populations from which these health workers migrate. For historical context to the problem, it is useful to recall the 1968 UN General

## PHYSICIAN EXPATRIATION RATES* — AFRICA TO OECD NATIONS, CIRCA 2000


- Countries with an expatriation rate of less then 15%
- Countries with an expatriation rate between 15% – 30%
- Countries with an expatriation rate between 31% – 50%
- Countries with an expatriation rate over 50%

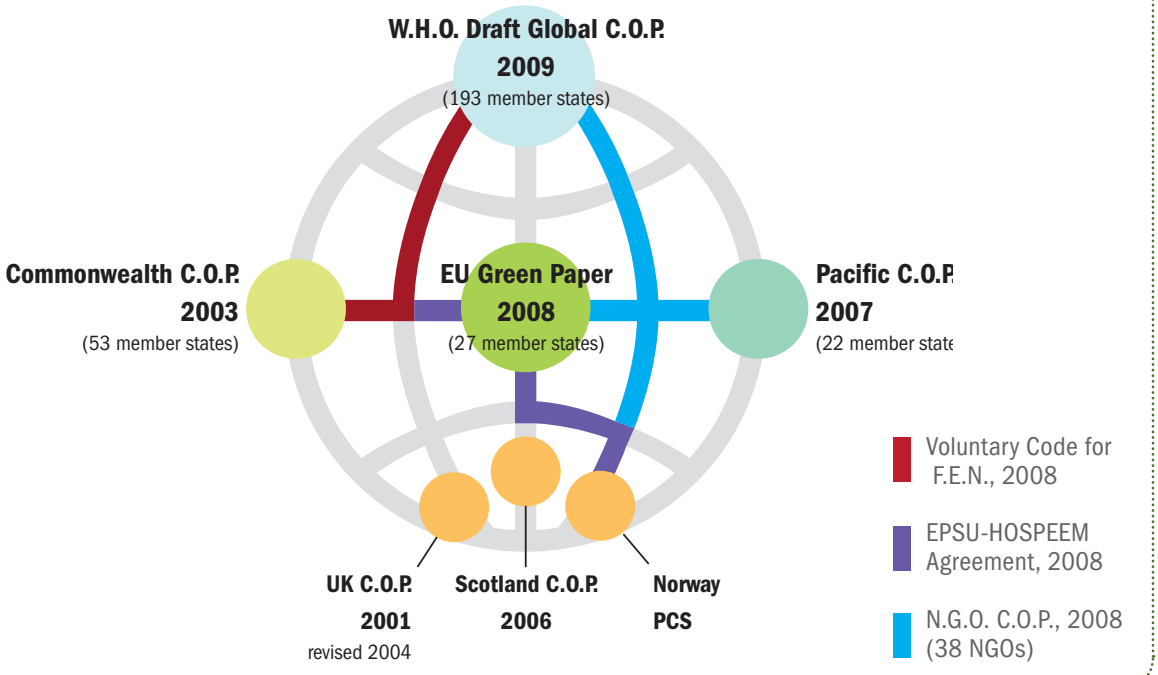
*__Expatriation rate__: percentage of a country's potential physician workforce working in OECD nations; i.e. a 50% expatriation rate would mean that there are as many country-born doctors working in OECD nations as there are working in-country.

Assembly Resolution 2417 (XXIII) titled, "Outflow of trained professionals and technical personnel from the developing to the developed countries, its causes, its consequences and the practical remedies for the problems resulting from it."[8] The problems identified in this resolution have remained largely unaddressed over the last forty years.

Encouragingly, the last decade has seen increasing attention paid to the issue of the international migration of health workers by both national and international policy makers, as well as the emerging development of a global ethical structure for its management. President Obama's recent statement in Ghana where he pointed to the link between incentives provided by donor nations, the migration of health workers, and the resulting negative impact on public health in source nations, evidences the growing political awareness around and the opportunity to meaningfully address this issue.[9]

Indeed, international architecture is fast emerging to more ethically and equitably manage the recruitment and migration of health workers. This structure includes international and regional ethical codes of recruitment, transnational codes of conduct, national and regional policies around recruitment, self-sufficiency, and shared responsibility, as well as bilateral agreements and memoranda of understanding both between the North and the South and amongst Southern countries themselves. Central to this emerging structure will be the WHO Code of Practice on the International Recruitment of Health Personnel that is to come before the World Health Assembly for potential adoption in May, 2010.

## GLOBAL ARCHITECTURE FOR ETHICAL MANAGEMENT OF HEALTH WORKER MIGRATION




## CALL FOR BILATERAL AGREEMENTS AS A HEALTH SOLUTION

The international architecture described above has emerged specifically to address the negative effects in source countries associated with the international migration of their health personnel. This structure places great emphasis on bilateral agreements as a solution to the adverse health effects in source countries from the emigration of health workers whose training they subsidized. The variety of instruments in the structure, including national, regional and international codes of practice, though largely voluntary, are important as they provide both the moral force and the normative content around the development of bilateral agreements.

Close examination of the text of the various instruments within the above described structure evidence the central role envisioned for bilateral agreements. The Pacific Code of Practice for Recruitment of Health Workers, in its section titled, "Strategies for Addressing the Effects of International Recruitment," states that, "Governments could [also] consider ***bilateral agreements to regulate the recruiting process, with the aim to minimize the adverse effects to the health care of the exporting country.***" The text expands on this language by stating, "Arrangements for recruitment between member governments could be conducted on the basis of these bilateral agreements in which both countries would have responsibility in ensuring compliance with the Code and meeting its obligations. Systemic recruitment could then take

place between these two countries under the agreed conditions." The Commonwealth Code of Practice on the International Recruitment of Health Workers contains this very same language in its companion document.[10]

Similarly, the E.U. Green Paper on Health Workforce outlines three possible areas of action to address the adverse effects from health worker migration, with one being, "***Stimulating Bilateral and Plurilateral agreements with source countries*** and developing mechanisms for support of circular migration."[11]

Likewise, the UK and Scotland Codes of Practice for the International Recruitment of Health Professionals both adopt as a guiding principle that "Developing Countries will not be targeted for recruitment, unless there is an ***explicit government-to-government agreement*** with the UK to support recruitment activities." The underlying purpose of the principle is to prevent the drain of valuable human resources from developing countries.[12]

Finally, and perhaps most importantly, the draft WHO Code of Practice on the International Recruitment of Health Personnel that is to come before the World Health Assembly in May, 2010 emphasizes the utilization of bilateral agreements as a health solution. The preamble of the draft WHO Code of Practice points to the "urgent need" to develop bilateral policy instruments to maximize the positive and to minimize the negative effects of health worker migration. One of the principal objectives of the Draft WHO Code of Practice is to "***provide guidance*** that may be used where appropriate ***in the formulation and implementation of bilateral agreements.***"[13] Moreover, the draft WHO Code of Practice sets forth as a central strategy in the Mutuality of Benefits section that "***Member States are urged to enter into bilateral, regional and multilateral arrangements*** that comply with this code to promote international cooperation and coordination on migrant health personnel recruitment processes."[14] The Draft WHO Code of Practice goes on to state, "***Such arrangements should strive to ensure that the balance between gains and loses in health worker migration should especially benefit developing countries and countries with economies in transition*** through the adoption of appropriate measures." The draft WHO Code of Practice in Article 5.3 further states that "Member States should abstain from active recruitment of health personnel from developing countries unless there exist ***equitable bilateral, regional, or multilateral agreement(s)*** to support recruitment activities."

It is clear from the examination of the above-cited instruments that bilateral agreements are viewed as a principle solution to the adverse health effects resulting from the international migration of health workers. While critical to implementation of the above described ethical structure, the composition of bilateral agreements as a health solution remains largely undefined. Indeed, WHO and OECD recently together called for a more thorough understanding of the role of bilateral agreements in addressing health worker migration.[15]

It should also be recognized that the lack of clarity on the precise form bilateral agreements may take in order to address the negative effects associated with health worker migration poses a particular

challenge for developing countries. Not only are developing countries often the most affected by the international migration of health personnel, as pointed to above, but they also may have less capacity and political capital to determine the content of bilateral agreements.

For all the above reasons, with a particular focus on serving the needs of developing countries that are particularly affected, the authors hope to provide some initial but concrete guidance on the development of bilateral agreements as necessary to further international cooperation to mitigate the negative effects associated with health worker migration.

The following sections of this report will provide an introduction to bilateral agreement, their legal status, point to the heterogeneity present in relation to bilateral agreements addressing the issue of health worker migration, as well as recent innovation in bilateral migration agreements that can serve to provide a way forward to ethically manage health personnel migration flows between source and destination countries. The authors will conclude by providing two model bilateral agreements that can serve to implement and ensure adherence with the recommendations presented in the draft WHO Code of Practice on the International Recruitment of Health Personnel.

The two model bilateral agreements presented in this report have been built by drawing directly from text and practice as present in existing bilateral agreements related to bilateral labor movement and health care cooperation. It is hoped that the model bilateral agreements will serve as a resource for countries seeking to formalize bilateral cooperation as specifically related to addressing the negative effects of health worker migration, in what has often been perceived as a contentious and intractable issue.

# 3 BILATERAL AGREEMENTS AND HEALTH WORKER MIGRATION

## INTRODUCTION TO BILATERAL AGREEMENTS

The previous section identified the variety of national and international instruments that call for bilateral agreements as a recommended method to mitigate the adverse effects associated with the international migration of health workers. It is useful to begin exploration of this topic by first defining the term "bilateral agreement" and placing it within the broader frame of both legally binding and non-binding bilateral instruments.

Bilateral understandings formalized in written instruments, whether intended to give rise to international legal obligations or simply to serve a normative or political purpose, are a mainstay of modern international relations. Such arrangements are an accepted device for maintaining structured, relatively formal, and ongoing relations between nation states. Lacking an international legislative body, bilateral agreements are of particular importance in the international effort to pursue common objectives.[16] While it is usually easiest to reach agreement in a bilateral context, there is often a need for broader elaboration of understandings as expressed through multilateral agreements. Both bilateral and multilateral agreements are important vehicles to address the international migration of health personnel, especially in the context of an increasingly internationally mobile health workforce.

## INTERNATIONAL LEGAL STATUS OF BILATERAL AGREEMENTS

Bilateral agreements can take a wide variety of forms, as reflected by the various nomenclature utilized to identify such agreements including "bilateral agreement," "co-operative agreement," "covenant," "memoranda of understanding," "memoranda of agreement," "concerted management agreement," "agreed minutes," and "notes verbales." The foregoing titles and associated forms though suggestive, are not themselves dispositive of whether an instrument is or is not legally binding or whether it is to be governed by international law. The Vienna Convention on Law of Treaties, as interpreted by the International Court of Justice in the case Qatar v. Bahrain, makes clear that the determination of whether an international agreement is legally binding depends fundamentally not on form but rather on whether the two participants intended to be so obligated. The intention of the parties or participants can be inferred from a variety of factors, including the text and the surrounding context, such as the status of the signatories.[17]

Moreover, many national governments provide their own specific guidance on how to ensure clarity that documents not meant to be legally binding are not interpreted as imposing legal duty. The United States Department of State, as an example, suggests specific formal, stylistic, and linguistic features in

order to ensure a document's non-binding nature.[18] With specific respect to the title, the United States Department of State suggests not utilizing the term "agreement" for non-binding instruments, but further cautions that use of the title "Memorandum of Understanding" is itself not sufficient to identify whether a particular agreement is or is not legally binding. The U.S. State Department recommends that in documents intended to be non-binding that the terms "parties," "shall," "agree," and "entry into force" be replaced by the terms "participants," "should," "intend to," and "is to come into operation." The U.S. State Department also suggests avoiding the clauses "done at," "concluded at," or speaking to the "equal authenticity of different languages."

Examination of the model bilateral agreements presented in section IV of this report, as well as the source bilateral agreements on which they were based, points to the differing use of language utilized to convey the intended legal nature of the instruments. A comparison of the text of the 2003 *United Kingdom- South Africa Memorandum of Understanding on the Reciprocal Exchange of Healthcare Concepts and Personnel* and the 2008 version of the M.O.U. between the two countries, both available through Annex A, provides powerful illustration of the above-described distinction. While there were few substantive changes made to the 2008 South Africa – United Kingdom M.O.U., the language in the 2008 version was clarified to ensure that it not be interpreted as legally binding under international law. As illustration, the terms "parties," "agree," and "enter into force" were changed to "participants," "accept," and "come into effect."

The authors would like to caution that while it is important to be able to distinguish between legally binding and non-binding international instruments, such distinction and its role in international relations can be and often is overemphasized. Christine Chinkin, an eminent legal theorist on the use of non-binding international instruments, makes the point that "drawing a formal distinction between hard and soft obligations is less important than understanding the processes at work within the law-making environment and the products that flow from it."[19] As further illustration, the US-China Memorandum of Understanding to Enhance Cooperation on Climate Change, Energy, and the Environment (available through Annex A), though lacking substance and legal status, formalized a significant cooperative process aimed at addressing the negative effects associate with climate change. Professor Chinkin's statement is a useful guide as we delve deeper into the form, substance and process that bilateral agreements, and indeed the associated WHO Code of Practice, can put into place in order to mitigate the adverse health effects of health worker migration.

## BILATERAL MIGRATION AGREEMENTS AS A HEALTH SOLUTION

The call for the use of bilateral agreements, as in the draft WHO Code of Practice, as a health solution to the adverse effects resulting from the international migration of health workers reflects a relatively new idea. In the past, the challenges associated with migration in general, and health worker migration specifically, have been addressed tangentially through piecemeal agreements in the sectors of education, labor, trade, and sometimes health.

A body of bilateral agreements focused specifically on managing migration flows and addressing the negative effects of health worker migration has not fully developed. This is due both to the significant political sensitivities associated with the topic of migration and the fact that the issue cuts across various sectors. Rather, a disparate group of bilateral agreements exist that touch on the various challenges associated with the international migration of health workers. These include bilateral labor agreements, bilateral social security agreements, bilateral health cooperation agreements, and bilateral economic integration agreements, including the associated mutual recognition agreements. Very recently, however, as will be examined later, there has been a growing trend towards the development of *bilateral migration agreements* that incorporate the concept of shared responsibility and take advantage of the ability to address the cross-linkages inherent in the topic.[20]

### Immigration History, National Immigration Policy, and Bilateral Agreements

With specific respect to the cross-cutting nature of the issue of health worker migration, in particular the variety of national and international approaches related to the international recruitment of health personnel, there are significant differences in whether national governments utilize bilateral agreements at all to manage migration flows, the types of agreements that they utilize, and the underlying purpose behind such agreements.

The utilization of bilateral agreements to manage health worker migration flows is most directly affected by a country's underlying immigration policy. In this connection, commentators have pointed to the significant regional differences in the development of immigration policies due to divergent immigration histories.[21] In particular, the fundamental approach to immigration in Western Europe, including Belgium, Britain, France, Germany, Netherlands, and Switzerland, is described in contrast to that employed in the Anglophone settler societies of Australia, Canada, New Zealand, and the United States. The former tend to prefer temporary migration while the latter are more accustomed to large-scale permanent migration.[22]

The movement of labor, including of health workers, as described above is centrally linked to destination country admission policies, usually requiring appropriate visas and work permits. Recruitment and admission can be based alternatively upon sector-based schemes, skill-based schemes, or bilateral agreements. Linked to the above described historical context, there is significant regional variation in the use of bilateral agreements with respect to the movement of highly skilled labor, including health workers. The use of bilateral agreements in recruiting and employing health workers is a central part of the immigration policy framework in most Western European nations. The use of bilateral 'guest worker' agreements, aimed at addressing the severe labor shortages in Western Europe following World War II, serves as important historical context and continue to shape perception of mass immigration and the utilization of bilateral agreements in the region.[23] The 'settler societies' of Australia, New Zealand and the United States have a fundamentally different approach based upon 'quality-selective' and 'non-discriminatory' immigration policies. Their use of bilateral agreements governing labor mobility is in sharp

distinction to that of Western European states. Canada utilizes a somewhat mixed approach based both upon a unilateral 'quality-selective' and 'non-discriminatory' approach to admission and accelerated migrant labor recruitment for select developing countries as formalized through bilateral agreements. Canada's bilateral agreements with the Philippines, utilized in development of our model bilateral agreement, points to the later approach. Asian countries continue to rely mostly on unilateral management of migration from Southern nations.

The above described divergence in approaches to facilitate labor admission, particularly the role of bilateral agreements in facilitating admission, is critical to better understanding the WHO Code of Practice's call for bilateral agreements as a solution to the adverse health effects in developing countries from the international migration of their health workers. While relatively easy for Western European nations to conceptualize how bilateral agreements might serve this purpose, such an approach is one that remains largely foreign in the Anglophone 'settler societies.' The WHO Code of Practice's call in particular that "Member States should abstain from active recruitment of health personnel from developing countries unless there exist ***equitable bilateral, regional, or multilateral agreement(s)*** to support recruitment activities" remains particularly troublesome for countries that do not utilize bilateral agreements to recruit health workers in the first place and rather rely on decentralized recruitment and national admission policies.

Despite regional variations in utilizing bilateral agreements to address issues related to health worker migration, agreements that formalize cooperation around the complex challenges related to the international migration of health personnel are an important strategy for all countries who are interested in better and more ethically managing health worker migratory flows. The authors, through the development of the two model bilateral agreements, aim to highlight approaches to cooperation specifically tailored to the issue of health worker migration. These approaches are suitable for both those who recruit directly through bilateral agreements and those who are concerned about health worker migration but rely on 'quality-selective,' 'non-discriminatory' admission, as well as decentralized approaches to recruiting health personnel.

## Current Approaches to Addressing Health Worker Migration through Bilateral Agreements

It is well recognized that bilateral agreements, in concert with national policies, are a crucial piece of the emerging international regulatory structure to more ethically and equitably address the gains and loses resulting from the migration of health workers. However, limited work has been done on the form and content that these necessary bilateral agreements should take.

As described earlier, there is significant variation in the types of bilateral agreements that governments enter into to manage the migratory flows of health workers. These include bilateral labor recruitment agreements, bilateral social security and welfare agreements, bilateral health cooperation agreements, and bilateral economic partnership/integration agreements. The increasingly sought

after mutual recognition agreements, with respect to the recognition of health worker credentials, is related to the later category.

An exhaustive inventory of bilateral agreements linked to the issue of health personnel mobility is a challenging task, due to the relative lack of agreements focused specifically in the area, the wide variety of piecemeal agreements associated with the topic, and the national sensitivities in making available the text of such agreements. There are reportedly already over a hundred bilateral agreements between states that intersect with the issue of health worker migration. Following is a list that builds on the considerable work of the Organization for Economic Co-operation and Development (OECD) and the International Organization for Migration (IOM) and includes additional secondary research and personal outreach.[24] Texts of highlighted (with asterisk) agreements are available through Annex A.

### Innovation in Managing Migration Flows through Bilateral Agreements: Contrasting 20th and 21st Century Bilateral Agreement Approaches

The dawn of this millennium witnessed explicit recognition by the global community of the broader role that migration plays in development, in terms of both positive and negative impact. The United Nations High Level Dialogue on Migration and Development, as well as the recent 2009 UN Development Report on the topic, evidence such recognition.[26] In concert with the migration and development movement, over the last few years, new forms of bilateral agreements have emerged that seek to more comprehensively manage migration flows, with a particular focus on harnessing migration flows to maximize development in both countries of origin and destination and to address source country concerns regarding "brain drain." These bilateral migration agreements, with the *France and Senegal Accord on the Concerted Management of Migratory Flows* as an example, stand in contrast to previous efforts to address the challenges to migration through piecemeal agreements focused on labor recruitment, social security and welfare protection, and economic integration.

The twentieth century model for bilateral labor mobility agreements, still highly prevalent today, is largely unilateral in its development. It is destination countries that usually drive the development of such agreements, with their primary interests that of addressing labor shortages, protecting special political and post-colonial relationships, promoting cultural ties, and facilitating liberalization of trade in services, as well as broader economic integration. The interests of source countries to enter such agreements include ensuring better living and working conditions for nationals, combating unemployment, and facilitating the acquisition of skills for their nationals.[27] It is in under this conception that a large number of health worker migration agreements have been developed, including a number of agreements that the Philippines have entered into.

However, as mentioned earlier, the last few years have witnessed the development of a new generation of bilateral agreements that look to enable development-friendly migration through a more comprehensive approach to managing migratory flows. Under this approach, the benefits and

## Bilateral Agreements and Health Worker Migration

A Partial Compilation

| Name | Notes |
|---|---|
| **UK-China** | Launched March 2006. Only UK agencies who appear on the Code of Practice list are allowed to participate in recruiting under the agreement; UK employers and recruiting agencies should only recruit through the Chinese recruitment agencies listed by the Chinese Ministry of Commerce; under no circumstances should any direct recruitment from China take place and no workers may be recruited from rural areas. |
| **UK-India** | Offers individual nurses the opportunity to work in England, excluding health workers from the Indian states of Andhra Pradesh, Madhya Pradesh, Orissa, and West Bengal. |
| ***UK-South Africa 2003 and 2008** | First signed October 2003 for a 5 year period. The agreement was renewed in 2008 for another 5 years. Facilitates exchange of health care workers and expertise. |
| **UK-Bulgaria** | In 2000, 33 Bulgarian nurses were recruited to a hospital in England |
| **UK-Spain** | Agreement provides for recognition of Spanish nurses' skills in the UK. |
| ***UK-Philippines** *(not renewed)* | Agreement for the transfer of "policy thinking" and education; UK allowed to recruit health care professionals. |
| ***Philippines-Bahrain** | Signed April 2007. Seeks to strengthen bilateral cooperation in the field of health services and the exchange of human resources; in addition to facilitating movement of health workforce, provides specific details on mechanisms to support human resources for health development in the Philippines. |
| **Philippines-Canada** | Agreements with the provinces of Saskatchewan, Manitoba, and British Columbia. Focused mainly on labor movement and social protection, though commit to support human resources development in Philippines, including describing funding mechanism for such purpose (Saskatchewan). |
| ***Philippines-Japan Economic Partnership Agreement** | Economic partnership signed in September 2006. Provides for Filipino nurses to go to Japan to obtain qualifications and professional or language training for up to four years. However, they must pass they must the national Japanese nursing exam. |
| **Philippines-Libya** | Filipino health workers deployed to Libya through a "government-to-government agreement." |
| **Philippines-Norway** | Launched 2003. For recruitment in health care. |
| **Philippines-Palau** | Signed April 2008. MOU on Medical Tourism/Medical Referral and Higher Education Training in Health. |
| **Philippines-Spain** | Signed June 2006. Allows entry of up to 100,000 Filipino health workers into Spain where they are afforded the same protections as Spanish workers. |
| ***Philippines-UAE** | Focused on labor mobility and social protection. |
| **South Africa-Cuba** | Launched October 1996. Provides for transfer of medical professionals through a series of renewable three-year contracts; designed to create a permanent flow of Cuban medical doctors and lecturers into South Africa. |
| **South Africa-Tunisia – Iran** | South Africa signed a cooperation agreement with Tunisia in 1999 and with Iran in 2004. Both these agreements provide for the training of South African doctors in each country. They also serve to promote scientific research, health policy and pharmaceutical development amongst other things. |
| **Spain-Colombia** | Comprehensive bilateral agreement, incorporating concepts of migration and human capacity development. |

## Bilateral Agreements and Health Worker Migration

A Partial Compilation

| Name | Notes |
|---|---|
| **Spain-France** | Allowed for Spanish nurses to work in France. The program lasted from 2002 to December 2004. |
| **Spain-Morocco** | Comprehensive bilateral agreement, incorporating concepts of migration and human capacity development. |
| ***Kenya-Namibia** | June 2004. Provides guidelines for temporary (unidirectional) movement of health workers from Kenya to Namibia upon request of Namibia. Formed as result of Kenya's inability to fully employ its health workers under terms of an IMF agreement. |
| **Fiji-Nauru** | Currently in negotiation. Fiji may provide health workers for Nauru to assist in an immediate shortage situation, and Nauru may provide funds to Fiji to produce new health workers to replace those who left under the agreement. |
| **China-Zambia** | Bilateral agreement that provides full medical scholarships for Zambians to study Chinese and medicine in China. |
| ***Sudan-Saudi Arabia** | Signed in 2009. Facilitates managed labor mobility between Sudan and Saudi Arabia as well as social protection and welfare. |
| **Indonesia-Japan** | Similar agreement to the one between Japan and the Philippines. |
| ***India-Denmark** | Facilitates managed labor movement of highly skilled workers and ensures their social protection and welfare. Specifically calls on cooperation between training facilities in both countries for mutual benefit. |
| **Poland-Netherlands "project"** | Allows Polish nurses to work in the Netherlands for a period. |
| **Canada-Switzerland** | Signed an "agreement protocol" to support mobility of health workers between the two countries. [25] |
| **Germany-Croatia**<br>**– Ukraine**<br>**– Poland**<br>**– Slovenia**<br>**– Czech Republic**<br>**– Slovak Republic**<br>**– Bulgaria**<br>**– Romania** | Germany signed bilateral agreements with each of these countries in 2005. The agreements organize the recruitment of foreign nursing aids. |
| **Italy-Romania** | Some Italian regions have signed bilateral agreements with Romanian provinces. |
| **Italy-Spain** | "Semi-formal" links with Spain to recruit Spanish nurses. |
| ***France-Benin** | Comprehensively addresses migration flows with a particular focus on health professionals and support for human resources for health development. |
| ***France-Senegal** | Similar to France-Benin, comprehensively addresses migration flows with a particular focus on health professionals and support for human resources for health development. |
| **Australia-New Zealand** | Trans-Tasman Mutual Recognition Agreement: agreed on mutual recognition of medical qualifications. |
| ***ASEAN Mutual Recognition Agreement**<br>**– Medical Practitioners**<br>**– Nursing Services**<br>**– Dental Practitioers** | Enables mutual recognition of medical, nursing and dental credentials within the ASEAN economic region. Of note, the agreements require respective terms of services of five, three, and five years in country before credentials are to be recognized. |

challenges of migration gain primacy alongside the focus on facilitating labor mobility and ensuring social protection for migrant workers.[28] Central to the development of bilateral migration agreements is the concept of shared responsibility, which reflects not just the needs and admission policies of the destination country, but engages with the various concerns of and identifies responsibilities for source countries and workers themselves.[29] This principle aims to engage the source country, destination country, and health workers themselves in mitigating the negative consequences of health worker migration, in ensuring effective circular migration, and in maximizing the development benefits resulting from migration. Of particular note, under this new paradigm, developing country concerns of "brain drain" is specifically recognized and addressed, rather than being sidelined or addressed tangentially.

France's agreement with Senegal is a good example of this new approach. As illustration, with particular relevance to the issue of health worker migration, the France-Senegal Agreement preamble includes in part the following language:

> *[Making] the issue of Migration and Development important to the 21st century; Eager to avoid the negative impact of migration on economic, social and cultural development in their countries; … ; Considering that the direction of migration must develop in a favorable prospect for each country's economic, social and cultural development and should not lead to a loss of skilled and vital resources for the country of origin; Noting that migration should encourage the increase of development in the country of origin, not only through the remittances of migrants, but also through the training and experience acquired by migrants during their stay in the destination country.*

The France–Senegal agreement goes into considerable detail on the substantive mechanisms to ensure that the vision articulated in the preamble is given effect. Notable mechanisms include creation of a migration observatory and process for exchange of information, including specifically in the context of brain-drain, details on health sector cooperation to take place such as the creation of a joint French - Senegalese faculty of medicine, support for reintegration of health workers, as well asand broader innovative efforts to ensure that migrant health personnel can contribute to broader development in source countries. The latter includes a program with France matching funds that Senegalese diaspora make available for development in Senegal. France's agreement with Benin similarly places very specific focus on addressing the negative effects in Benin from the international migration of its health workers. Spain similarly has entered into migration specific agreements with Morocco and other West African states. Other bilateral agreements that explicitly adopt this shared responsibility or migration and development approach include those between Philippines and Bahrain, as well as between India and Denmark (available through Annex A).

The authors believe that the 21st century model of comprehensive bilateral migration agreements holds great promise both for facilitating the transparent and orderly movement of health workers and also for addressing many of the challenges resulting from this migration. Our first model bilateral agreement, available in section V, utilizes such an approach. It includes not only provisions related to health worker recruitment and protection of migrant health workers, but also gets

to the point of ensuring that the migration itself generates health benefits for the those that remain behind in the source country. This model bilateral agreement builds upon existing practice and links specifically to the recommendations as presented in the revised WHO Draft Code of Practice that is to come before the World Health Assembly for adoption in May of 2010.

It is useful here to reemphasize that concerted bilateral migration agreements are most relevant for those destination countries where the bilateral agreements themselves serve as a mechanism for recruitment and facilitation of the labor movement. For those countries that have "quality selective," "non-discriminatory" admission policies and where recruitment is conducted through a decentralized mechanism, a different approach to bilateral agreements is necessary. Recognizing this need, the authors have developed a second bilateral agreement that builds in the process for cooperation with respect to the issue of health worker migration but that does not identify precise details on the issues of recruitment, admission, and associated health cooperation. As identified earlier, the second model bilateral agreement has been based upon the US-China Memorandum of Understanding to Enhance Cooperation on Climate Change, Energy, and the Environment.

# 4

# AREAS DESERVING FURTHER ATTENTION

## UNILATERAL, BILATERAL, OR MULTILATERAL APPROACHES: POTENTIAL SOURCES OF TENSION

Given that there is no single comprehensive legally binding international agreement to manage migratory flows, mechanisms are need to ensure that migration, particularly of valuable human resources, contributes to the development of both source and destination nations. The international management of migration continues to be subject to unilateral immigration policy, bilateral agreements, and the multilateral agreement General Agreement on Trade in Services (GATS) with respect to the temporary movement of natural persons (Mode 4).[30] The process towards development of the WHO Code of Practice on the International Recruitment of Health Personnel itself reflects the need for an internationally coherent process towards managing the effects of migration. From the perspective of those specifically interested in addressing the negative effects of health worker migration, the question arises as to which of these mechanisms is most useful in serving the purpose of improving health for all and whether there are underlying tensions between the approaches.

Unilateral immigration policy remains the dominant mechanism utilized to manage international migration flows.[31] This approach allows complete assertion of national sovereignty. Yet there is also growing recognition, identified earlier in this report, that broader international cooperation around managing migration would be useful and is needed in response to what is an increasingly internationally mobile health workforce and health systems with critical shortages. We have been reminded on several occasions that a single failed health system jeopardizes health globally.

The General Agreement on Trade in Services (GATS), a multi-lateral agreement with a powerful dispute settlement mechanism, stands in contrast to the unilateral approach to managing migration. GATS, however, is unable to address cross-linkages outside of trade, including in areas affecting human rights and human capacity development.[32] Moreover, it has become increasingly apparent that the movement of high skilled workers does not generate benefits for all as such movement, unlike in the case of goods, is not substantially bidirectional.[33] For these and a number of associated reasons, GATS has seen few Mode 4 commitments made by member states in the areas associated with health worker migration. Indeed, GATS Mode 4 accounts for only between 0% to 4% of all GATS commitments, with ninety percent of the GATS Mode 4 concessions made relating to corporate executives, managers, and transfers.[34]

Despite the relatively small contribution to internationally managing health worker migration, GATS and its objective of encouraging economic growth and development through sole focus on

liberalizing trade in services has resulted in the call for and development of mutual recognition agreements. Indeed, mutual recognition of qualification has been identified "as one of the most significant factors inhibiting the mobility of labor across borders."[35] Five of the bilateral agreements analyzed and made available through Annex A, pointed as one of their goals to achieve a mutual recognition agreement with the destination country. These include the Sudan-Saudi Arabia agreement, as well as that of the Philippines current agreements with Bahrain, British-Columbia, and Manitoba, as well as its expired agreement with the United Kingdom.

A significant question arises whether the mutual recognition agreements that are being sought, as for example the *ASEAN Mutual Recognition Agreement for Medical Practitioners, Nursing, and Dental Practitioners*, are able to address the challenges associated with health worker migration. Are there mechanisms that can ensure that mutual recognition agreements address the negative health effects associated with health worker migration? For example, is the five-year practice requirement in the country of training, as called for the *ASEAN MRA for Medical Practitioner*s, enough of a remedy to address the challenges associated with health worker migration? Another associated question that arises is with respect to the movement towards global standardization of medical and nursing curriculum at a time when others, including at the WHO, are calling for more context appropriate training. Is the global standardization of curriculum going to lead to increased health worker migration and away from the context driven and retention focused locally driven curricula or is there a mechanism to ensure improved quality and access to health services for all?

Bilateral agreements in the past focused more on facilitating labour mobility than addressing the challenges associated with migration. Moreover, the older generation of bilateral agreements were largely unilateral in their development.[36] Over time, however, there is growing evidence of real cooperation between source and destination countries, including on what are deemed as significant priorities of source countries. Concerns regarding "brain-drain" have been raised over the last four decades by developing countries in response to developed country migration policies, both unilateral and as facilitated through bilateral agreements, focused mainly on selecting highly skilled personnel. The authors of this report believe that the 21st century comprehensive bilateral migration agreements provide a way forward to both facilitate transparent recruitment and migration of highly skilled health personnel as well as to address the negative effects resulting from such movement. **Model Bilateral Agreement I**, building on existing practice, is aimed to guide such cooperation.

## RELEVANCE OF PROCESS AND TRANSPARENCY

Meaningful cooperation, as formalized through bilateral agreements, is needed to address the challenges associated with health worker migration and can lead to "wins" for the source country, the destination country, and for migrant health workers. The process that bilateral agreements put into place to facilitate such cooperation is equally as important as the substance around potential solutions to

addressing the challenges. This is particularly so as there remains lack of complete data on the extent of the adverse effects and lack of consensus on the specific steps forward.

Examination of the bilateral agreements listed in Annex A provides illustration of the variety of mechanisms that can be put into place to ensure ongoing dialogue and cooperation. These include development of implementation related bodies titled variously, "Joint Commission for the Follow-up of the Agreement of Cooperation;" "Joint Consultative Committee," "Joint Bilateral Committee," "Joint Working Group," "Working Committee," "Joint Parliamentary Committee," and "Joint Coordinating Committee." The US-China Climate Change M.O.U., also available through Annex A, is notable is in that while it has few substantive areas of agreement it explicitly puts into place, with significant supporting detail, a Climate Change Policy Dialogue and Cooperation platform. The US-China Climate Change M.O.U. is a useful model for nation states that seek to cooperate around the issue of health worker migration but are not yet certain of the exact steps or measure of cooperation. The Model Bilateral Agreement II, available in section V, is based on the US-Climate Change M.O.U.

All of the above identified implementation and cooperation bodies create the space for meaningful dialogue and cooperation on what is an undoubtedly complex and highly sensitive issue. Further examination is however necessary to determine whether the implementation and cooperation bodies created operate in practice as they were intended to.

The above question raises the broader issue of transparency. There continues to be significant confidentiality around and hesitancy in making available the actual texts of bilateral agreements. Despite the variety of reported bilateral agreements related to the issue of health worker migration, it is difficult to get access to the precise texts of such agreements. This is reflected in the relatively limited number of agreements whose texts we were able to compile.

The lack of access to the texts of bilateral agreements and information on the functioning of the above cited implementation and cooperation bodies has multiple negative effects, particularly for developing countries. First, the lack of easy access makes it difficult to learn from the variety of relevant practices already in place. Recognizing what others are already cooperating on would provide leverage to those developing countries that are impacted and concerned but believe the issue to have little traction. Moreover, without opening up the texts of bilateral agreements to public/civil society scrutiny, the governments cannot be held accountable to that which they have agreed upon. Developing countries are, again, particularly affected as the international community is unable to mediate the power dynamics inherent in bilateral relations.

For all the above reasons, there is an express need to continue to advocate for transparency in making available the texts of bilateral agreements and information on associated processes. It is also the reason for the development of the model bilateral agreements that follow, which in particular specific areas of potential cooperation with regard to the complex and highly sensitive issue of health worker migration.

# 5 MODEL BILATERAL AGREEMENTS

The following two model bilateral agreements have been developed in order to clarify the potential content of bilateral agreements to address health worker migration; to capture existing and innovative practice in terms of both substance and process; to further adherence to and implementation of the draft WHO Code of Practice on the International Recruitment of Health Personnel; and to serve as a guide for those, particularly developing countries, interested in engaging in bilateral agreements with the aim of mitigating the adverse effects of health worker migration.

**Model Bilateral Agreement I** is targeted towards source and destination nations that utilize bilateral agreements for health personnel recruitment and admission purposes and are seeking to enter a comprehensive agreement to specifically address the negative effects associated with the international migration of health personnel. This model would be especially conducive to managing health worker migration flows between nations that have a particularly strong relationship, one that could well have emerged from a shared colonial history.

Model Bilateral Agreement I is based almost exclusively on text and existing best practice as present in health care and labor cooperation related bilateral agreements, as well as on provisions present in the draft WHO Code of Practice on the International Recruitment of Health Personnel. **Model Bilateral Agreement I** puts into practice all the substantive recommendations proposed in the draft WHO Code of Practice, as identified through footnotes.

A list of the referenced agreements, abbreviated and color-coded in the model agreement can be found in Annex A. The full text of referenced agreements is available on the Global Health & Development page of The Aspen Institute's website at http://www.aspeninstitute.org/policy-work/global-health-development. The draft WHO Code of Practice on the International Recruitment of Health Personnel is provided in Annex B.

**Model Bilateral Agreement II** is relevant for those countries that recognize the importance and urgency for cooperative action with respect to the international migration of health workers but are unsure of the precise steps forward. Governments who do not themselves recruit health personnel and rather rely on 'quality-selective', 'non-discriminatory' migration. policies to facilitate entry to health personnel would find this approach of particular utility.

This second Model Bilateral Agreement is based on the *Memorandum of Understanding to Enhance Cooperation on Climate Change, Energy and Environment between the Government of the United States of America and the Government of the People's Republic of China*. Full text of the US-China Climate Change M.O.U. can be found on the Global Health & Development page of The Aspen Institute's website at http://www.aspeninstitute.org/policy-work/global-health-development.

## MODEL BILATERAL AGREEMENT I

Agreement on the Concerted Management of Health Personnel Migratory Flows

Between the Government of [Source Country]

And

The Government of [Destination Country][37]

The Government of [Source Country] and the Government of [Destination Country], hereinafter referred to as Contracting Parties;[38]

Recognizing their long-standing and friendly relations;[39]

Wishing to develop further their bilateral cooperation as related to the international migration of health personnel, based on the principles of mutual benefit,[40] and as urgently called for in the [draft] WHO Code of Practice on the International Recruitment of Health Personnel to maximize the benefits and mitigate the negative impact from such migration;

Conscious of the global health workforce shortage;

Aware that the shortage and imbalanced distribution of health personnel within countries and throughout the world constitutes a significant threat to the performance of health systems in developing countries;[41]

Eager, in particular, to avoid the negative effects of the international migration of health workers on economic, social and cultural development in the two countries;[42]

Committed to ensuring that the international migration of health personnel provide favorable prospect for each countries' economic, social and cultural development and not lead to a loss of skilled and vital resources for the country of origin;[43]

Noting that the international migration of health personnel should encourage the increase of development in the country of origin, not only through the remittances of migrants, but also through the exchange of knowledge, expertise, and technical and financial assistance between the contracting parties with a focus on health workforce development;[44]

Determined to protect the social welfare of migrant health personnel of the Contracting Parties[45] and to make every effort to support the development of skills and to encourage temporary migrant health personnel migrants to return to the country of origin with enhanced and appropriate skills;[46]

Recognizing that such collaboration is in support of the commitment to fulfill the Millennium Development Goals and in furthering the strategic plans of both the Contracting Parties in the health sector;[47] Recognizing also the need for institutionalizing such cooperation and desirous

of concluding a bilateral agreement for this purpose, the Contracting Parties hereby agree as follows:[48]

## DEFINITIONS

For the purposes of this agreement, the following terms are defined as follows:

a) "Source Country" refers to the country, usually one that is low-income or a country with economy in transition, whose health personnel nationals are employed in significant proportion within the borders of the other contracting party.

b) "Destination Country" refers to the country, usually one of high income, where a significant proportion of the source country's health personnel are employed.

c) "Health Personnel" refers to all people engaged in the public and private sector whose primary intent is to enhance health, and covers those working on a temporary or permanent basis.[49]

d) "Migrant Health Personnel" is limited to the health personnel who have migrated internationally ("emigrated") from source country to destination country.

### I. Objectives

The Contracting Parties accept that this agreement is entered into with the view to clarify and articulate their respective intentions to promote and strengthen areas of cooperation as related to the international migration of health personnel.[50]

Specific objectives of the agreement include to:

(a) Provide an ethical framework that will guide migrant health personnel recruitment, deployment, and employment policies and procedures of the Contracting Parties, [51] including ensuring social protection and increased transparency in the entire process related to sending and receiving [Source Country] health personnel;[52]

(b) Promote the development of health-related research and training institutions and develop mechanisms for the sustainable development of human resources for health;[53]

(c) Create alliances between [Source Country] and [Destination Country]'s recognized healthcare and educational institutions to produce sustainable international education, training, and professional/technical development programs that will increase the supply, ensure appropriate skill mix, and improve the quality of human resources for health;[54]

(d) Support the reintegration of migrant health personnel into [Source Country]'s health system;[55]

(e) Support migrant health personnel in furthering broader development related efforts in [Source Country];[56]

(f) Implement through this agreement the policies, standards, and practices recommended in the draft WHO Code of Practice on the International Recruitment of Health Personnel.[57]

### II. Recruitment Standards

The Contracting Parties agree on a basis of reciprocity to regularly exchange information related to the international recruitment and deployment of health personnel.[58] The Joint Bilateral Committee, as identified in Article V, will serve to facilitate such information exchange.[59]

The Contracting Parties shall exchange information on and support linkages between registered

[Destination Country] Employers and approved [Source Country] Sending Agencies through processes which ensure that all participants are informed concerning any contractual arrangements formalized between [Destination Country] Employers and [Source Country] Sending Agencies prior to the recruitment of health personnel.[60]

The Contracting Parties shall strive to promote direct contact between [Destination Country] Employers and the state managed or private recruiting agencies in the [Source country] without intermediaries to facilitate the informed and orderly recruitment of health personnel.[61]

[Destination Country] Employers shall identify regularly and in writing the health personnel cadres and areas of specialties to be recruited, identify specialties which can directly host candidates and those where further training is required within or outside the [Destination Country], the number of health professionals and experts required, the nature of expertise required, the required period of service, and the proposed terms of service.[62]

The Contracting Parties intend that [Destination Country] Employers shall pay the costs related to the recruitment and deployment of health personnel. Employers and Sending Agencies must not request, charge or receive, directly or indirectly, any payments from a person seeking employment in [Destination Country] which contravenes the laws of [Destination Country].[63, 64]

[Destination Country] in engaging in recruitment activities in [Source Country] shall take into account the impact of such activities on the health system of the [Source Country]. To the extent that recruitment activities are conducted by the private sector, so far as permitted under domestic law, shall seek to regulate such activity in such manner as to take into account the impact of such activity on the health system of.[65]

Unless mutually agreed upon by the Contracting Parties, [Destination Country] Employers shall not seek to recruit health care personnel who have an outstanding legal obligation to the health system of [Source Country], such as a fair and reasonable contract of service.[66, 67]

Nothing in this agreement should be interpreted as limiting the freedom of [Source Country] health personnel, in accordance with international law, to migrate to [Destination Country] if wishing to admit and employ them.[68]

### III. Employment Standards

***(i) Labor Contract***

Candidates for recruitment from [Source Country] should be provided by [Destination Country] Employers with an internationally accepted contract that conforms to the national policies and relevant legislation of both Contracting Parties with details on the specific position, job description, and associated terms and conditions.[69, 70]

As part of their contract, migrant health personnel shall be provided opportunity to develop their qualifications, training, education and expertise. Candidates for recruitment should additionally receive information highlighting the attributes of living and working in [Destination Country], including on workers' rights and benefits under [Destination Country] labor legislation, on the local community, including access to public services, established social networks, and available cultural support.[71]

All migrant health personnel shall be employed under a formal employment contract duly signed by the employer and the worker.[72]

***(ii) Equal Treatment/ Workers' Rights***

Health personnel recruited from [Source Country] shall receive equal treatment with nationals of [Destination Country] in the application of the relevant labor and employment laws of the later. Migrant health personnel shall enjoy full rights and privileges accorded to any worker in [Destination Country] in accordance with the provisions of the labor and the social security laws of [Destination Country] and relevant ILO Conventions.[73]

[Source Country] health personnel in particular shall be provided equal employment opportunity in terms of pay and other employment conditions, including access to training, education and related career development opportunities and resources, as well as the right to due process in cases of violation of the employment contract.[74] [Destination Country] Employers shall utilize the services of migrant health personnel within the scope of their training and expertise and shall provide the necessary medical supplies and equipment or instruments for the execution of their duties.[75]

## IV. Migration and Development

The Contracting Parties are committed to supporting health workforce and health system, as well as broader socio-economic, development in [Source Country] as linked to the international migration of health personnel.[76] The Contracting Parties will support initiatives based as far as practicable upon the national programs and policy priorities established by the Government of [Source Country] to sustain and promote such development. Implementation of initiatives is to be guided by the principle of mutual benefit, with special focus that net benefits accrue to [Source Country].[77]

As such, the Contracting Parties agree to progressively implement the following programs:

*a) Exchanges*

The Contracting Parties shall facilitate mutual access to universities, colleges and schools of training for health personnel during scientific studies, specific training, postgraduate training, and study visits.[78]

Exchange visits of experts and specialists in various health fields between the two parties will be based according to needs determined by each Contracting Party.[79]

*b) Scholarships*

Scholarships under this Agreement shall strive to develop human resources for health that can also serve as educators.[80]

The [Destination Country] government shall provide graduate and post-graduate scholarship programs that will be administered by providing scholarships to [Source Country] health personnel to leading [Destination Country] Universities. Upon completion of the program, the scholars shall be required to return to the [Source Country] under the administrative guidelines of the [Source Country] government where they shall be required to serve in hospitals, universities and other health institutions.[81]

*c) Strengthening Health Personnel Training Institutions and Health Research Institutions*

The Contracting Parties shall initiate a program that will encourage joint ventures and investments in health facilities including training hospitals, research institutions, information technology-enabled health services operations and other relevant ventures and investments as relevant.[82]

The Contracting Parties will support initiatives and co-operate with each other and the appropriate educational credential issuing authorities to establish training and education programs to

improve the education and training opportunities in [Source Country].[83]

*d) Reintegration of Migrant Health Personnel*
[Source Country] and [Destination Country] undertake to develop and implement concerted strategies to enable the reintegration of [Source Country] migrant health professionals into the [Source Country] health system. Both Contracting Parties will mobilize the means of cooperation for returning health personnel to benefit [Source Country] by enabling returning health personnel to exercise their profession in public or private settings in a manner that is as beneficial as possible.[84]

*e) Technology Transfer*
The Contracting Parties shall support transfer of technology, including joint research and projects and sharing of best practices in the health services sector. They shall also identify areas of excellence vis-à-vis priority areas for research and development in both countries to enable researchers to benefit from each others expertise/specialization, as subject to intellectual property rights.[85]

*e) Participation of Migrant Health Personnel to the Development of [Source Country]*
[Source Country] and [Destination Country] will develop strategies on how to best mobilize the expertise and resources of [Source Country] migrant health personnel in [Destination Country] to further socio-economic development in [Source Country].[86]

Potential actions to include:

1) Facilitating mobility and movement of health personnel across Contracting Party borders in order to enable health personnel to participate in the training or specific mission related to the development of [Source Country];[87]

2) Creating a General Observatory of Migration Flows between [Source Country] and [Destination Country], with a particular focus on those with technical higher education;[88]

3) Assisting the utilization of migrant health personnel savings for investment in [Source Country] through potential implementation of tax deferred and matching co-development financial mechanisms;[89]

4) Contracting Parties commitment to study precisely how to improve efficiency in the transfer of funds, reduce related costs, and support use of transferred funds for development purposes;[90]

5) Supporting initiatives focusing on the local development of particular regions of origin of health personnel migrants, including through support for microfinance institutions.[91]

In making available the necessary financial support for the above described programs, the [Destination Country] Government will additionally seek contributions and/or donations from [Destination Country] Employers operating under the auspices of this agreement. The Joint Bilateral Committee, identified in Article V, may request audits and other reports on the amount and use made of such funds.[92]

## V. Monitoring and Implementation

The Contracting Parties agree to constitute within three (3) months of the signing of this agreement a ***Joint Bilateral Committee*** with two to three members from each side to be nominated through diplomatic channels.

The Joint Bilateral Committee shall meet once a year, alternatively in the two countries, and is provided with the mandate to:[93]

a) Interpret the provisions of the bilateral agreement and create guidelines on the implementation of this agreement, including identification of a designated national coordinator and contact agency in both [Source Country] and [Destination Country].[94]

b) Facilitate, coordinate, and monitor the progress of joint cooperative activities and otherwise consult on the adherence to this agreement.[95]

c) Recommend initiatives to address any issues that might arise in the context of this agreement.[96]

d) Facilitate cooperation between the Parties in producing periodic reports to the WHO Director General on the topic of health worker migration and joint activities undertaken, as called for in the draft WHO Code of Practice.

e) Suggest amendments to this agreement as necessary for better achievement of its objectives.[97]

The funding for the Joint Bilateral Committee shall be jointly determined by the Contracting Parties.[98]

### VI. Dispute Resolution

Any dispute between the Contracting Parties, which may arise in the course of the implementation and interpretation of this agreement, will be settled amicably by the Joint Bilateral Committee mentioned in Article IV and, failing that, through consultation and negotiation between the Contracting Parties.[99]

### VII. Entry into Force, Amendment, Termination

This Agreement shall enter into force on the date of the later written notification by the Contracting Parties, through diplomatic channels, indicating that the domestic requirements for its entry into force have been complied with.[100] The Agreement shall remain in force for a period of five (5) years and may be extended for a similar period unless one party officially notifies the other of its desire to amend, suspend or terminate the Agreement (6) six months prior to its intended date of expiration.[101] The Agreement may be amended with the mutual written consent of the Contracting Parties. Any such amendments will come into effect on the date determined by the Contracting Parties and will form a part of the Agreement.[102]

Unless otherwise agreed, the suspension or termination of the Agreement will not affect the validity and duration of any ongoing arrangements, programmes and projects undertaken under this Agreement, until the completion of such programmes or activities.[103]

The foregoing record represents the agreement reached between the Government of [Source Country] and the Government of [Destination Country] upon the matters referred therein.[104]

Signed in duplicate in the English language, both texts having equal validity.

Done at …….. on this …….. day of …….. .

For the [Source Country] Government

For the [Destination Country] Government

## MODEL BILATERAL AGREEMENT II

Memorandum of Understanding
To Enhance Cooperation on Health Worker Migration

Between

The Government of [Destination Country]

And

The Government of [Source Country]

The Government of [Destination Country] and the Government of [Source Country] (hereafter referred to as "the Participants"), recognize the following:

That an adequate and accessible health work force is fundamental to the maintenance of a strong health system and, given the global shortage of health workers, is among the greatest challenges facing [Destination Country] and [Source Country];

That the imbalanced distribution of health workers throughout the world, in particular the shortage in Sub-Saharan Africa, undermines health systems of developing countries;

Cooperation between [Destination Country] and [Source Country] in respect of migration of health workers is critical to the realization of the highest attainable standard of health in both countries;

Cooperation on the migration of health workers can serve as a pillar of the bilateral relationship, build mutual trust and respect, and lay the foundation for constructive engagement between [Destination Country] and [Source Country] for years to come while also contributing to multilateral cooperation.

The Participants have therefore reached the following understanding:

### I. Purpose

The purpose of this Memorandum of Understanding ("MOU") is to strengthen and coordinate our respective efforts to establish and promote principles, standards and practices for ethical recruitment of health personnel in order to achieve a balance between the rights, obligations and expectations of [Source Country], [Destination Country] and migrant health personnel.

Both countries commit to respond vigorously to the challenges of the global shortage of health workers, and its impact on the health systems of both countries, through ambitious domestic action and international cooperation.

Both countries resolve to pursue areas of cooperation where good expertise and resources can accelerate progress towards mutual goals. These include, but are not limited to:

1) ethical international recruitment of health workers;

2) freedom of health workers, in accordance with international law, to migrate;

3) fair employment and contractual practices, and equal opportunity, for health personnel;

4) maintenance of strong health systems in both countries;

5) minimizing of the adverse impact of health worker migration on the health system of [Source Country];

6) providing measures to strengthen the health system of [Source Country] where [Destination Country's] recruitment activities have an adverse impact on the [Source Country] health system;

7) meaningful reporting and transparency with respect to health worker migration; and

8) amicable settlement of disputes between the Participants.

Whenever possible, cooperation should seek to include expertise from all sectors of society and provide incentives for engagement at the sub-national level as well as by the private sector and non-governmental organizations.

### II. Implementation

This MOU is to be co-chaired by the Department of ____ on the [Destination Country] side and the Department of _____ on the [Source Country] side. The Participants intend to hold regular ministerial consultations to deepen mutual understanding and promote and guide bilateral cooperation on health worker migration through a range of measures, including:

**Health Worker Migration Policy Dialogue and Cooperation**

The Participants have decided to establish Health Worker Migration Policy Dialogue and Cooperation as a platform for the [Destination Country] and the [Source Country] to address the adverse effects associated with health worker migration and to identify and resolve areas of concern.

Consistent with equity and their common but differentiated responsibilities, and respective capabilities, the [Destination Country] and [Source Country] recognize they have a very important role in combating the adverse effects of health worker migration. The Participants recognize the ongoing importance of the GLOBAL CODE OF PRACTICE ON THE INTERNATIONAL RECRUITMENT OF HEALTH PERSONNEL, adopted by [The World Health Assembly], and are committed to the observance of its Guiding Principles and general terms. The Participants will work together to further promote the effective observance and sustained implementation of the WHO COP's terms and principles by the international community.

The Participants concur that their Health Worker Migration Policy Dialogue and Cooperation should promote (i) discussion and exchange of views on domestic and international policies for addressing the adverse effects of health worker migration; (ii) practical solution that provide benefits to both countries; and (iii) cooperation on specific projects that mitigate the adverse effects associated with health worker migration.

The Participants intend to hold consultations between ministerial level representatives of the two

countries on a regular basis. The Participants may establish working groups or task forces involving relevant ministries as necessary to support the objectives of the Health Worker Migration Policy Dialogue and Cooperation.

### III. Other Mechanisms for Cooperation

New initiatives or other mechanisms for cooperation intended to achieve the goal of this MOU may be established with the mutual consent of both countries. Existing bilateral efforts may also be included as part of the cooperation described in this MOU, with such mutual consent.

Cooperation under this MOU may commence upon the date of signature and is not intended to give rise to rights or obligations under international law.

GOVERNMENT OF [DESTINATION COUNTRY]

By: .....

Date:.....

GOVERNMENT OF [SOURCE COUNTRY]

By: .....

Date: .....

6

# ANNEXES

## ANNEX A

*List of Bilateral Agreements Utilized in the Development of Model Agreements*

- Co-operative Agreement between the Ministry of Health of the Kingdom of Saudi Arabia and the Democratic Republic of Sudan [S-S}
- Memorandum of Understanding between the Department of Labour and Employment of the Government of the Republic of the Philippines and Her Majesty the Queen in the Right of the Province of Saskatchewan as represented by Minister Responsible for Immigration and the Minister of Advanced Education and Employment Concerning Cooperation in the Fields of Labour, Employment, and Human Resource Development [P-S]
- Memorandum of Understanding between the Department of Labour and Employment of the Government of the Republic of the Philippines and the Department of Labour and immigration of the Government of Manitoba, Canada Concerning: Co-operation in Human Resource Deployment and Development [P-M]
- Memorandum of Understanding between the Department of Labour and Employment of the Government of the Republic of the Philippines and the Ministry of Economic Development of British Columbia, Canada Concerning Co-operation in Human Resources Development and Deployment [P-BC]
- Memorandum of Agreement the Government of the Republic of the Philippines and the Government of the Kingdom of Bahrain on Health Services Cooperation [P-B]
- Memorandum of Understanding between the Government of the Republic of the Philippines and the Government of the United Arab Emirates in the Field of Manpower [P-UAE]
- Memorandum of Understanding between the Government of the United Kingdom of Great Britain and Northern Ireland and the Government of the Republic of South Africa on the Reciprocal Educational Exchange of Healthcare Concepts and Personnel [UK – SA '03]
- Memorandum of Understanding between the Government of the United Kingdom of Great Britain and Northern Ireland and the Government of the Republic of South Africa on the Reciprocal Educational Exchange of Healthcare Concepts and Personnel [UK-SA 08]
- Memorandum of Understanding Between The Government of the Republic of the Philippines and the Government of the United Kingdom of Great Britain and Northern Ireland in Healthcare Cooperation (expired) [UK-P]

- Memorandum of Understanding between the Ministry of Health and Social Services of the Government of the Republic of Namibia and the Ministry of Medical Services of the Government of Republic of Kenya [N-K]

- Memorandum of Understanding on Labour Mobility Partnership between the Republic of India and the Kingdom of Denmark [I-D]

- ASEAN Mutual Recognition Agreement on Medical Practitioners [ASEAN MRA]

- ASEAN Mutual Recognition Agreement on Dental Practitioners [ASEAN MRA]

- ASEAN Mutual Recognition Agreement on Nursing Services [ASEAN MRA]

- Japan – Philippines Economic Partnership Agreement [J-P]

- Accord Concerning Migratory Flows between the Government of the Republic of France and the Government of the Republic of Senegal [F-S]

- Accord Concerning Migratory Flows and Co-development between the Government of the Republic of France and the Government of the Republic of Benin [F-B]

- Memorandum of Understanding to Enhance Cooperation on Climate Change, Energy, and Environment between the Government of the United States of America and the Government of the People's Republic of China [US-China Climate Change]

*Full text of all cited bilateral agreements available on the Global Health & Development page of The Aspen Institute's website at http://www.aspeninstitute.org/policy-work/global-health-development.*

# ANNEX B

*Draft WHO Code of Practice on the International Recruitment of Health Personnel*

**Note**

Three types of update have been introduced in the draft code:

1. changes reflecting the views expressed by regional committees during their sessions held in 2009. The main changes are followed by attribution to the regional committees in brackets with **bold** typeface;
2. brackets have been used to indicate comments made by Member States for which there were different options (also in **bold**);
3. the Secretariat introduced new text to reflect some general views expressed by Member States.

## *Preamble* [Regional Committee for the Western Pacific]

The Member States of the World Health Organization:

Recalling the 2009 ministerial declaration of the Economic and Social Council reaffirming its commitment to strengthening health systems that deliver equitable health outcomes as a basis of a comprehensive approach, noting with concern the lack, as well as the imbalanced distribution of health workers within countries and throughout the world, in particular the shortage in sub-Saharan Africa, which undermines health systems of developing countries, and encouraging the finalization of a Code of Practice on International Recruitment of Health Personnel;

Further recalling resolutions WHA57.19 and WHA58.17 in which the Health Assembly requested the Director-General to develop a WHO code of practice on the international recruitment of health personnel in consultation with all relevant partners;

Noting the call in the Kampala Declaration adopted at the First Global Forum on Human Resources for Health (Kampala, 2–7 March 2008) for WHO to accelerate negotiations on the WHO code of practice;

Further noting the G8 communiqués of 2008 and 2009 encouraging WHO to accelerate the development and adoption of a WHO code of practice;

Recognizing the work undertaken in the United Nations and other international organizations on strengthening the capacity of governments to manage migration flows at national and regional levels and the need for further action, at both national and global levels, on international recruitment of health personnel;

Recognizing that an adequate and accessible health workforce is fundamental to an integrated health system and for the provision of essential health services;

Conscious of the global shortage of health workers;

Deeply concerned that the severe shortage of health workers in many Member States constitutes a major threat to the performance of health systems and undermines the ability of these countries to achieve the Millennium Development Goals and other internationally agreed development goals;

Alarmed that the migration of highly educated and trained health personnel from countries with health systems in crisis is increasing, further weakening the health systems of the countries of origin;

Deeply concerned that, as a result of global interdependence, compromised national health systems can have health and security implications for the global community;

Affirming that all Member States have the sovereign right and responsibility to strengthen their health systems in order to progressively achieve full realization of the right of everyone to the enjoyment of the highest attainable standard of health;

Recognizing that, while international migration of health personnel can bring mutual benefits to both source and destination countries, the balance of gains and losses of health personnel migration should have a net positive impact on the health systems of developing countries; **[Regional Committee for Africa, Regional Committee for the Americas, Regional Committee for South-East Asia, Regional Committee for Europe, Regional Committee for the Eastern Mediterranean, Regional Committee for the Western Pacific]**

Deeply determined that this code should be implemented in such a way as to protect and strengthen the health systems of developing countries; **[Regional Committee for Africa, Regional Committee for the Americas, Regional Committee for South-East Asia, Regional Committee for Europe, Regional Committee for the Eastern Mediterranean, Regional Committee for the Western Pacific]**

Recognizing the importance of balancing the relation between the rights of health personnel, including their right to leave their countries and to migrate to countries that wish to admit and employ them, and the right to the highest attainable standard of health of the populations of Member States; **[Regional Committee for the Americas, Regional Committee for Europe, Regional Committee for the Eastern Mediterranean]**

Recognizing that improving the social and economic status of health workers, their living and working conditions, their opportunities for employment and their career prospects is an important step in overcoming existing shortages and improving retention of a skilled health workforce;

Mindful of the historic and continuing relevance of the role of international exchange in ideas, values and people to human well-being;

Recognizing that the complexity of the challenge demands a comprehensive response and a multisectoral approach, encompassing all sectors associated with both migration and the determinants of health;

Recognizing the urgent need to formulate national, bilateral, regional and other international policy instruments for promoting effective international cooperation and national action in order to maximize the benefits and mitigate the negative impact of international migration of health personnel;

Emphasizing the need for technical and financial assistance to developing countries and countries with economies in transition that are working to strengthen their health systems, including health personnel

development; **[Regional Committee for Africa, Regional Committee for the Americas, Regional Committee for Europe]**

Stressing that the WHO code of practice on the international recruitment of health personnel will be a core component of national and global responses to the challenges of health worker migration;

THEREFORE:

The Member States hereby agree on the following articles which are recommended as a basis for action.

### *Article 1 – Objectives*

The objectives of this code are:

(a) to establish and promote voluntary principles, standards and practices for the ethical international recruitment of health personnel in order to achieve a balance between the rights, obligations and expectations of source countries, destination countries and migrant health personnel;

(b) to serve as an instrument of reference for Member States in establishing or to improving the legal and institutional framework required for the international recruitment of health personnel and in formulating and implementing appropriate measures;

(c) to provide guidance that may be used where appropriate in the formulation and implementation of bilateral agreements and other international legal instruments, both binding and voluntary;

(d) to facilitate and promote international discussion and advance cooperation on matters related to the ethical international recruitment of health personnel as part of strengthening health systems, with a particular focus on the situation of developing countries. **[Regional Committee for Africa, Regional Committee for the Americas, Regional Committee for South-East Asia, Regional Committee for Europe, Regional Committee for the Eastern Mediterranean, Regional Committee for the Western Pacific]**

### *Article 2 – Nature and scope*

2.1 The code is voluntary. Member States and other stakeholders are strongly encouraged to comply with the code.

2.2 The code is global in scope and is directed towards Member States, health personnel, recruiters, employers, health-professional organizations, relevant subregional, regional and global organizations, whether governmental or nongovernmental, and all persons concerned with the international recruitment of health personnel.

2.3 The code applies to all health personnel, including all people engaged in actions in the public and private sectors whose primary intent is to enhance health, and covers those working on a temporary or permanent basis.

2.4 The code provides ethical principles applicable to the international recruitment of health personnel in a manner that strengthens the health systems of developing countries and promotes an equitable balance of interests among source countries, destination countries and health personnel.

### *Article 3 – Guiding principles*

3.1 Addressing present and expected shortages in the health workforce is crucial to protecting global health. International migration of health personnel can make a sound contribution to the development and strengthening of a national health workforce. However, the setting of voluntary international standards and the coordination of national policies on international health personnel recruitment are desirable in order to advance an ethical framework to equitably strengthen health systems worldwide, to mitigate the negative effects of health personnel migration on the health systems of developing countries and to safeguard the rights of health personnel. **[Regional Committee for Africa, Regional Committee for the Americas, Regional Committee for South-East Asia, Regional Committee for Europe, Regional Committee for the Eastern Mediterranean, Regional Committee for the Western Pacific]**

3.2 All Member States have the sovereign right and responsibility to strengthen their health systems in order to progressively achieve full realization of the right of everyone to the enjoyment of the highest attainable standard of health. Member States should take the code into account when developing their national health policies and cooperating with each other, as appropriate.

3.3 The specific needs and special circumstances of countries, especially those developing countries and countries with economies in transition that are particularly vulnerable to health workforce shortages and/or have limited capacity to implement the recommendations of this code, should be considered. Destination countries should, to the extent possible, provide technical and financial assistance to developing countries and countries with economies in transition aimed at strengthening health systems, including health personnel development [, to offset the loss of health workers]. **[Regional Committee for Africa, Regional Committee for the Americas]**

3.4 Member States should balance the relation between individual rights of health personnel to leave any country including their own in accordance with international law, and the right to the highest attainable standard of health of the populations of source countries in order to mitigate the effects of migration on the health systems of the source countries. However, nothing in this code should be interpreted as limiting the freedom of health personnel, in accordance with international law, to migrate to countries that wish to admit and employ them. **[Regional Committee for the Americas, Regional Committee for Europe, Regional Committee for the Eastern Mediterranean]**

3.5 International recruitment of health personnel should be conducted in accordance with the principles of transparency, fairness and mutuality of benefits. Member States, in conformity with national legislation and applicable international legal instruments to which they are a party, should promote and respect fair labour practices for all health personnel. All aspects of the employment and treatment of migrant health personnel should be without distinction of any kind, such as race, colour, gender, religion, national or social origin, the country where they were trained, birth or other status.

3.6 Member States should strive to create a sustainable health workforce and work towards establishing effective health workforce planning, production and retention strategies that will reduce their need to recruit migrant health personnel. Policies and measures to strengthen the health workforce should be appropriate for the specific conditions of each country and should be integrated with national development programmes.

3.7 Effective gathering of national and international data, research, and sharing of information on the international recruitment of health personnel are essential to achieve the objectives of this code and should be prioritized out of a spirit of solidarity and to achieve global health security. **[Regional Committee for Europe, Regional Committee for the Eastern Mediterranean]**

3.8 Member States, health personnel, recruiters, employers, health-professional organizations, relevant subregional, regional and international organizations, whether governmental or nongovernmental, and all persons concerned with the international recruitment of health personnel should collaborate in the fulfilment and implementation of the objectives contained in this code for the benefit of present and future generations in all countries.

***Article 4 – Migrant health personnel: responsibilities, rights and recruitment practices***

4.1. Health personnel and health professional organizations should seek to cooperate fully with national and local authorities in the interests of patients, health systems, and of society generally. **[Regional Committee for the Americas, Regional Committee for Europe]**

4.2 Recruiters should not seek to recruit health care personnel who have an outstanding legal responsibility to the health system of their own country such as a fair and reasonable contract of service. Destination countries should try to be aware of and respect such responsibilities. **[Regional Committee for the Eastern Mediterranean]**

4.3 Member States and other stakeholders should recognize that ethical international recruitment practices provide health personnel with the opportunity to assess the benefits and risks associated with employment positions and to make timely and informed decisions.

4.4 Member States should, to the extent possible, ensure that recruiters and employers observe fair and just recruitment and contractual practices in the employment of migrant health personnel and that migrant health personnel are not subject to improper or fraudulent conduct. Migrant health personnel should be hired, promoted and remunerated based on objective criteria such as levels of qualification, years of experience and degrees of professional responsibility on the basis of equality of treatment with the domestically trained health workforce. Recruiters and employers should provide migrant health personnel with relevant and accurate information about any health personnel position that they are offered.

4.5 Member States should ensure that, subject to national laws and relevant international legal instruments to which they are a party, migrant health personnel enjoy the same legal rights and responsibilities as the domestically trained health workforce in all terms of employment and conditions of work.

4.6 Measures should be taken to ensure that migrant health personnel enjoy opportunities and incentives to strengthen their professional education, qualifications and status on the basis of equality of treatment with the domestically trained health workforce. All migrant health personnel should be offered appropriate induction and orientation programmes that enable them to operate safely and effectively within the health system of the destination country.

4.7 Member States should, to the extent possible, strive to ensure that the services performed in connection with the recruitment and placement of migrant health personnel are rendered free of charge to such health personnel.

### *Article 5 – Mutuality of benefits*

5.1 In accordance with the guiding principle of mutuality of benefits, as stated in Article 3 of this code, the health systems of both source and destination countries should derive benefits from the international migration of health personnel. In developing and implementing international recruitment policies, Member States should strive to ensure that the balance of gains and losses of health personnel migration should have a net positive impact on the health systems of developing countries and countries with economies in transition. **[Regional Committee for Africa, Regional Committee for the Americas, Regional Committee for South-East Asia, Regional Committee for Europe, Regional Committee for the Eastern Mediterranean, Regional Committee for the Western Pacific]**

5.2 Member States are urged to enter into bilateral, regional and multilateral arrangements that comply with this code to promote international cooperation and coordination on migrant health personnel recruitment processes. Such arrangements should strive to ensure that the balance between the gains and the losses in health worker migration should especially benefit developing countries and countries with economies in transition through the adoption of appropriate measures. Such measures may include the provision of effective and appropriate technical assistance, support for health personnel retention, support for training in source countries that is appropriate for the disease profile of such countries, twinning of health facilities, support for capacity building in the development of appropriate regulatory frameworks, access to specialized training, technology and skills transfers, and the support of return migration, whether temporary or permanent. **[Regional Committee for Africa, Regional Committee for Europe, Regional Committee of the Western Pacific]**

5.3 International health personnel recruitment should be done in such a way that it seeks to prevent a drain on valuable human resources from developing countries. Member States should abstain from active recruitment of health personnel from developing countries unless there exist equitable bilateral, regional or multilateral agreement(s) to support recruitment activities. **[Regional Committee for Africa, Regional Committee for the Americas, Regional Committee for Europe, Regional Committee for the Eastern Mediterranean]**

5.4 Member States should seek to ensure that international health personnel recruitment should be sensitive to local health care needs so that international recruitment from any country should not destabilize local health care provision. **[Regional Committee for the Eastern Mediterranean]**

5.5 Member States should recognize the value both to their health systems and to health personnel themselves of professional exchanges between countries and of opportunities to work and train abroad. Member States in both source and destination countries should encourage and support health personnel to utilize work experience gained abroad for the benefit of their home country. Measures should be taken to enable migrant health personnel to develop their qualifications, training, education and expertise so that, when returning home, whether on a temporary or permanent basis, they could add value to the health systems in the source country. **[Regional Committee for Europe, Regional Committee for the Eastern Mediterranean, Regional Committee of the Western Pacific]**

### *Article 6 – National health workforce sustainability and retention*

6.1 As the health workforce is central to sustainable health systems, Member States should take effective measures to educate, retain and sustain a health workforce that is appropriate for the specific conditions of each country, including areas of greatest need, and is built upon an evidence-based health workforce plan. All Member States should strive to meet their health personnel needs with their

own human resources for health, as far as possible. **[Regional Committee for the Americas, Regional Committee for Europe, Regional Committee for the Western Pacific]**

6.2 Appropriate educational and vocational training are core ingredients of a quality health workforce. Member States should consider strengthening educational institutions to scale up the training of health personnel and developing innovative curricula to address current health needs. Member States should undertake steps to ensure that appropriate training takes place in the public and private sectors. **[Regional Committee for Africa, Regional Committee for Europe, Regional Committee for the Western Pacific]**

6.3 Member States should recognize that improving the social and economic status of health personnel, their living and working conditions, their opportunities for employment and their career prospects is an important means of overcoming existing shortages and improving retention of a skilled health workforce. Member States should consider adopting and implementing effective measures aimed at long-term financial commitment to strengthening health systems, continuous monitoring of the health labour market, and coordination among all stakeholders in order to develop and retain a sustainable health workforce responsive to their population's health needs. Member States should adopt a multisectoral approach to addressing these issues in national development programmes. **[Regional Committee for Africa, Regional Committee for the Americas, Regional Committee for Europe, Regional Committee for the Eastern Mediterranean, Regional Committee for the Western Pacific]**

6.4 Member States should consider adopting measures to address the geographical maldistribution of health workers and to support their retention in underserved areas. These measures could include changes in the educational approaches to favour the selection of students from rural backgrounds, providing clear career paths and career development programmes, improving the infrastructure such as health-care facilities, and providing a decent wage, as well as appropriate financial incentives. Member States should also consider other issues surrounding health personnel retention such as non-monetary incentives, including improving working and living conditions, housing, and education benefits for children of health personnel. **[Regional Committee for Africa, Regional Committee for Europe]**

### *Article 7 – Data gathering and research*

7.1 Member States should recognize that the formulation of effective policies on the health workforce requires a sound evidence base.

7.2 Member States should establish or strengthen, as appropriate, programmes for national data gathering on health personnel migration, including the migration of students in health-related fields, and its impact on health systems. Member States should collect and analyse data that are required to support effective health workforce human resource policies and planning.

7.3 Member States should establish or strengthen, as appropriate, national research programmes in the field of health personnel migration and coordinate such research programmes through partnerships at the regional and international levels. To this end, Member States should ensure that appropriate research is conducted into all aspects of international recruitment of health personnel.

7.4 Member States should ensure, as much as possible, that comparable data are generated and collected pursuant to paragraphs 7.2 and 7.3 above for ongoing monitoring, analysis and policy formulation.

### *Article 8 – Information exchange*

8.1 Member States should, as appropriate and subject to national law, promote the establishment or strengthening of information exchange on international health personnel migration and health systems, nationally and internationally, through public agencies, academic and research institutions, health professional organizations, and subregional, regional and international organizations, whether governmental or nongovernmental.

8.2 In order to promote and facilitate the exchange of information that is relevant to this code, each Member State should, to the extent possible:

(a) progressively establish and maintain an updated database of laws and regulations related to health personnel recruitment and migration and, as appropriate, information about their implementation;

(b) progressively establish and maintain updated data from national data gathering programmes in accordance with Article 7.2; and

(c) provide data collected pursuant to subparagraphs (a) and (b) above to the WHO Secretariat every three years, beginning with an initial data report within two years after the adoption of the code by the Health Assembly.

8.3 For purposes of international communication, each Member State should, as appropriate, designate a national authority responsible for the exchange of information regarding health personnel migration and the implementation of the code. Member States should communicate the designated national authority to WHO. The designated national authority should be authorized to communicate directly or, as provided by national law or regulations, with designated national authorities of other Member States and with the WHO Secretariat and other regional and international organizations concerned, and to submit reports and other information to the WHO Secretariat pursuant to subparagraph 8.2(c) above and Article 10.1.

8.4 A register of designated national authorities pursuant to paragraph 8.3 above shall be established, maintained and published by WHO.

### *Article 9 – Implementation of the code*

9.1 The code should be publicized and implemented by Member States in collaboration with health personnel, recruiters, employers, health professional organizations, subregional, regional, and international organizations, whether governmental or nongovernmental, and other interested stakeholders.

9.2 Member States should establish and maintain an effective legal and administrative framework at the local and national level, as appropriate, to give effect to the code.

9.3 Member States should consult, as appropriate, with representatives of health-professional organizations, recruiters, employers, nongovernmental organizations and other stakeholders, in decision-making processes and involve them in other activities related to the international recruitment of health personnel.

9.4 All stakeholders referred to in Article 2.2 should understand their shared responsibilities to work individually and collectively to ensure that the objectives of this code are achieved. All stakeholders should observe this code, irrespective of the capacity of others to observe the code. Recruiters and employers should cooperate fully in the observance of the code and promote the principles expressed by the code, irrespective of a Member State's ability to implement the code.

9.5 Member States should to the extent possible, maintain a record, updated at regular intervals, of all recruiters authorized by competent authorities to operate within their jurisdiction.

9.6 Member States should, to the extent possible, monitor and regulate public and private recruiters and employers to promote adherence with this code.

9.7 Member States should encourage and promote good practices among recruitment agencies by only employing those agencies that comply with the [ethical principles of the] code.

***Article 10 – Monitoring and institutional arrangements***

10.1 Member States should periodically report, as appropriate, to the WHO Secretariat on measures taken, results achieved and difficulties encountered in implementing this code. The initial report should be made within two years after the adoption of the code by the Health Assembly and [reports thereafter should be made every three years] / [the periodicity of reporting thereafter should be decided by the Health Assembly]. The purpose of the monitoring process is to identify challenges and successes in implementing the code and to assist countries in building capacity to implement the code.

10.2 The Director-General shall keep under review the implementation of this code, on the basis of periodic reports received from designated national authorities pursuant to Articles 8.3 and 10.1 and other competent sources, and periodically report to the Health Assembly on the effectiveness of the code in achieving its stated objectives and suggestions for its improvement. The initial report shall be made within three years after the adoption of this code by the Health Assembly and [reports thereafter should be made every three years] / [the periodicity of reporting thereafter should be decided by the Health Assembly].

10.3 The Director-General shall:

(a) support the information exchange system and the network of designated national authorities specified in Article 8;

(b) develop guidelines and make recommendations on practices and procedures and such joint programmes and measures as specified by the code or as may be required to make the code effective; and

(c) maintain liaison with the United Nations, the International Labour Organization, the International Organization for Migration, and other competent regional and international organizations as well as concerned nongovernmental organizations to support implementation of the code.

10.4 Nongovernmental organizations and other interested stakeholders are invited to report their observations on activities related to the implementation of the code to the WHO Secretariat.

10.5 The Health Assembly should periodically review the relevance and effectiveness of the code. The code should be considered a dynamic text that must be brought up to date as required.

### *Article 11 – Partnerships, technical collaboration and financial support*

11.1 Member States and other stakeholders should collaborate directly or through competent international bodies to strengthen their capacity to implement the objectives of the code, taking into account the needs to protect and strengthen the health systems of developing countries.

11.2 International organizations, international donor agencies, financial and development institutions, and other relevant organizations should increase their technical and financial support to assist the implementation of this code and support health system strengthening in developing countries and countries with economies in transition that are experiencing critical health workforce shortages and/or have limited capacity to implement the objectives of this code. Such organizations and other entities should cooperate with countries facing critical shortages of health workers and undertake to ensure that funds provided for disease-specific interventions are used to strengthen health systems capacity, including health personnel development. **[Regional Committee for Africa]**

11.3 Member States recruiting health personnel from developing countries or countries with economies in transition [[should] / [may wish to] provide] technical assistance to the latter, aiming at strengthening health systems capacity, including health personnel development in those countries. **[Regional Committee for Africa, Regional Committee for the Americas, Regional Committee for Europe]**

11.4 Voluntary financial mechanisms supportive of efforts of developing countries and countries with economies in transition to strengthen health systems, including health personnel development, should be explored. **[Regional Committee for Africa, Regional Committee for the Americas]**

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## ENDNOTES

[1] The low-density of health workers, particularly physicians, has been shown to be significantly associated with high maternal mortality, poor immunization coverage, and high infant and child mortality. See Anand, Sudhir and Barnighausen, Till, Human Resources and Health Outcomes: Cross-Country Econometric Study, Lancet, 2004:364,1603-1609.
[2] See Gunilla Backman and Paul Hunt, "Health Systems and the Right to Health: An Assessment of 194 Countries," Lancet; 372 (2008): 2047-2085.
[3] See WHO Fact Sheet, "Global Health Workforce Crisis and its Impact," available at http://www.who.int/mediacentre/factsheets/fs302/en/index.html.
[4] See World Health Report 2006 "Working Together for Health." available at http://www.who.int/whr/2006/en/.
[5] See "Immigrant Health Workers in OECD Countries in the Broader Context of Highly Skilled Migration," International Migration Outlook, SOPEMI 2007, OECD, Paris.
[6] Id.
[7] See Hagopian, Amy et al. "The Migration of Physicians from Sub-Saharan Africa to the United States of America: Measures of the African Brain Drain," Human Resources for Health, 2004, vol2: 17.
[8] See 1968 UN General Assembly Resolution 2417 (XXIII), "Outflow of trained professionals and technical personnel from the developing to the developed countries, its causes, its consequences and the practical remedies for the problems resulting from it," available at http://www.un.org/documents/ga/res/23/ares23.htm.
[9] See President Obama's July 11, 2009 speech in Ghana. Full text of the speech available at http://www.huffingtonpost.com/2009/07/11/obama-ghana-speech-full-t_n_230009.html.
[10] See Pacific Code of Practice for Recruitment of Health Workers. Available at http://www.wpro.who.int/NR/rdonlyres/6B618EAA-B30B-4CFA-8038-A9F145174895/0/Pacificcodeofpractice.pdf. See also Commonwealth Code of Practice for the International Recruitment of Health Workers. Available at http://www.thecommonwealth.org/shared_asp_files/uploadedfiles/%7B7BDD970B-53AE-441D-81DB-1B64C37E992A%7D_CommonwealthCodeofPractice.pdf.
[11] See EU Green Paper on Health Workforce. Available at http://ec.europa.eu/health/ph_systems/docs/workforce_gp_en.pdf.
[12] See UK Code of Practice for the International Recruitment of Health Professionals. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4097730.
[13] See WHO Draft COP Article 1(c), available in Annex B.
[14] See WHO Draft COP Article 5(2), available in Annex B.
[15] See "International Migration of Health Workers: Improving International Cooperation to Address the Global Health Workforce Crisis," a Joint WHO-OECD Policy Brief. Available at http://www.who.int/hrh/resources/oecd-who_policy_brief_en.pdf.
[16] See Fitzmaurice, Maglosia and Elias, Olufemi, "Contemporary Issues in the Law of Treaties," Eleven International Publishing, 2005.
[17] See full text of the International Court of Justice Judgment on the Court's website at http://www.icj-cij.org.
[18] See US State Department Guidance at http://www.state.gov/s/l/treaty/guidance/index.htm.
[19] See Shelton, Dinah (ed.), "Commitment and Compliance: The Role of Non-Binding Norms in the International Legal System," Oxford University Press, 2000.
[20] See Panizzon, Marion, "Bilateral Migration Agreements and the GATS: Sharing Responsibility Versus Reciprocity," Journal of Migration and Refugee Issues, Vol.5-3, 2009.
[21] See Freeman, Gary, "Modes of Immigration Politics in the Liberal Democratic States," International Migration Review, vol. 29(4).
[22] Id.
[23] Id.
[24] See IOM Report, "Compendium of Good Practice Elements in Bilateral Temporary Labour Arrangements," Global Forum on Migration and Development. Available at http://www.iom.int/jahia/webdav/shared/shared/mainsite/published_docs/studies_and_reports/compendium_version_2.pdf. See also OECD, "International Migration Outlook," SOPEMI, 2007, Paris.
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[26] See UN High Level Dialogue on Migration and Development website. Available at http://www.un.org/migration/. See also UNDP Human Development Report 2009, "Overcoming Barriers: Human Mobility and Development." Available at http://hdr.undp.org/en/reports/global/hdr2009/.
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[53] Memorandum of Agreement the Government of the Republic of the Philippines and the Government of the Kingdom of Bahrain on Health Services Cooperation
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## NOTES

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